

# **RHODE ISLAND DEPARTMENT OF HEALTH**

## **Application for Health Plan Certification / Re-certification**

### **Assurances**

Citations refer to the *Rules and Regulations for the Certification of Health Plans (R23-17.13-CHP)* (herein HP).

I am aware of Chapter 23-17.13 of the General Laws of the state of Rhode Island, as amended, and the standards, rules and regulations prescribed thereunder, which regulate the operation of health plans. If certification is granted I, for and on behalf of the applicant/Health Plan, hereby bind the Health Plan and agree to the following:

1. To comply with all statutory and regulatory requirements.
2. To adhere to any and all applicable state and federal laws.
3. That all policies/procedures presented in this application for Health Plan certification are approved by the governing body/CEO, and have been or will be implemented and incorporated into the applicant's operations throughout the certification period unless modified according to HP section 2.5.
4. The Health Plan will disclose to prospective and current enrollees the information as defined and required by HP section 4 and Appendix "A."
5. Notification of any proposed, systemic change to the attached Health Plan certification application information, or that information on file at the Rhode Island Department of Health (Department) related to the Health Plan, will be provided to the Department. If the Department does not disapprove of the modification within ninety (90) days of the receipt of all necessary information, the modification shall be deemed approved. {HP 2.4, 2.5}
6. The Health Plan will not refuse to contract with, or compensate for covered benefits, an otherwise eligible provider or non-participating provider solely because that provider has in good faith communicated with one or more of his/her patients regarding the provisions, terms, or requirements of the Health Plan, as they relate to the needs of that provider's patient. {HP 5.1}
7. The Health Plan will not terminate any physician/other provider contract(s) "without cause". {HP 5.3}
8. The Health Plan will not enter into any compensation agreement with any provider of covered services or pharmaceutical manufacturer pursuant to which specific payment is made directly or indirectly to the provider as an inducement or incentive to reduce or limit services, to reduce the length of stay or the use of alternative treatment settings or the use of a particular medication with respect to an individual patient. {HP 5.4}
9. The Health Plan will publicly notify professional providers within the Health Plan's geographic service area of the opportunity to apply for credentials when the Health Plan contemplates adding providers according to R23-17.13. {HP 5.6}
10. The Health Plan will not exclude a professional provider of covered benefits from participation in its provider network based solely on the professional provider's degree or type of license as applicable under state law; or the lack of affiliation with, or admitting privileges at a hospital, if such lack of affiliation is due solely to the professional providers' type of license. {HP 5.8}
11. The Health Plan will not discriminate against providers solely because the provider treats a

substantial number of patients who require expensive or uncompensated medical/health care.  
{HP 5.9}

12. As applicable, the Health Plan will comply with the *Rules and Regulations for the Utilization Review of Health Care Services* pursuant to Chapter 23-17.12 of the General Laws of Rhode Island as amended.
13. The Health Plan will provide reports and information required on forms prescribed by the Department to determine if the Health Plan is in compliance with the provisions of Chapter 23-17.13 of the General Laws of Rhode Island, as amended. Required quarterly reports will be submitted to the Department sixty (60) days after the end of each quarter of the calendar year. Required annual reports will be submitted to the Department ninety (90) days after the end of each calendar year. {HP 8.1}

**Person authorized by Applicant/Entity to provide the above assurances in connection with the Health Plan's certification application:**

**Signature:** \_\_\_\_\_

**Title:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**For the Health Plan Named:** \_\_\_\_\_

*State of (.....)*

*County of (.....)*

*In....., in said county on this.....day of.....A.D.*

*20....., personally appeared before*

*me.....*

*Of..... who, after signing the foregoing ownership report in my presence, made oath that the facts stated in said report are true.*

**NOTARY PUBLIC**

November 2003